Cc:
☐ Teacher (s)
☐ PE Teacher
Office use only

DOWNEY UNIFIED SCHOOL DISTRICT
ASTHMA CARE PLAN & MEDICATION AUTHORIZATION
(Must be completed annually)

SCHOOL YEAR: ______________________________ **SCHOOL** ____

CHILD'S NAME ____ **D.O.B** ___________________ **GRADE**_________________

The above named pupil is required to take medication prescribed by a physician during the regular school day. I request that designated School District personnel assist my child in taking the medication in accordance with the instructions provided below by the physician. I authorize the District to communicate with the physician below regarding my child's medical condition and/or the medication prescribed for it. *If authorized by physician below, I consent to self-administration of ____ Asthma Inhaler ___ Epi-Pen and release the district and school personnel from civil liability in the event of an adverse reaction to the medication.*

I have read and acknowledge both front and back of this form.

_______________________ ____________________________________ ____
Date Telephone Signature of Parent/Guardian

Asthma triggers: ____Exercise ___Dust __Strong odors/fumes ____Pollens __Animals other _________________

Emergency Information:
Name of parent or guardian: _________________________ **Cell Phone:** _____________________________________
Work Number: ____ **Home Phone:** ___________________________________

TO BE COMPLETED BY PHYSICIAN

MEDICATION TO BE GIVEN AT SCHOOL: (If Any):

Name of Medication	Dosage	Dose Form (HFA, Nebulizer, Tab, Liquid, Etc.)	Time

List all additional Asthma/Allergy/Respiratory Medications given at home:

Name of Medication	Dosage	Dose Form (HFA, Nebulizer, Tab, Liquid, Etc.)	Time

Steps to be followed in an Emergency Situation:

1. ____

2. ____

Special Directions or Limitations applying to the student while at school: (To be completed by Physician and Parent):

1. ____

2. ____

Office Stamp - REQUIRED

The pupil named above for whom this medication is prescribed, is under my care.

_________________________________ _________________________________
Print Name of Physician **Signature of Physician - REQUIRED**

____
Address Telephone Date

Physician: Please check if applicable: **I verify this student has demonstrated knowledge of correct dosage and usage of: □ Asthma inhaler** and/or **□Epinephrine Pen and as the prescribing physician I request the student to carry this medication on his/her person while at school.**

FIRST AID FOR ASTHMA ON REVERSE SIDE

Medication Regulations on reverse side

DOWNEY UNIFIED SCHOOL DISTRICT
Asthma Attack First Aid

FOLLOW INSTRUCTIONS AS ORDERED ON THE ASTHMA CARE PLAN FOR NON-LIFE THREATENING ASTHMA SYMPTOMS

IF THE STUDENT HAS ANY OF THE FOLLOWING SEVERE ASTHMA SYMPTOMS:

1. Student was given prescribed medication and no improvement is seen within 10-15 minutes or
2. Student has a hard time breathing with:
    - Chest and neck pulled in while breathing or
    - Child is hunched over or
    - Child is struggling to breath or
3. Trouble walking or talking or
4. Stops playing and can't start activity again or
5. Lips or fingernails are gray or blue

FIRST AID for a Severe Asthma Attack.

◊ If the medication does not work and the student is getting worse **Call 911** and call the student's parents at once.
◊ Call the school nurse.
◊ Have the student remain upright; reassure the student and don't expect student to walk or talk as student needs what breath he/she has to get sufficient oxygen.
◊ Give sips of water if student says it helps.
◊ If the student stops breathing initiate CPR.
◊ Record any treatment/medication given the student on the **Daily Log of Medication Administered**.

It is important to remember that students who are having an asthma attack can be in serious danger. It's important to stay with them at all times and get emergency care at once.

IMPORTANT NOTICE TO PARENTS!

UPON THE SIGNED WRITTEN REQUEST OF A PARENT OR LEGAL GUARDIAN, DISTRICT PERSONNEL MAY ASSIST PUPILS TO TAKE PRESCRIBED MEDICATIONS DURING THE REGULAR SCHOOL DAY ONLY UNDER ALL OF THE FOLLOWING CONDITIONS:

○ The parent or legal guardian of the child requests that during school hours District personnel assist the pupil in taking medication, which is prescribed by a licensed physician. The request must be filed with the school site administrator or school nurse.

○ The prescribing physician completes a signed statement which details the method, dosage amount, dose form and time schedules by which such medication is to be taken as well as the name of the medication, purpose of the medication, prescription date and expiration date (of medication), and length of time medication will be necessary.

○ The parent or legal guardian of the pupil consents in writing to contact the prescribing physician relevant to the medical condition or medication and instructs the physician to answer any questions posed by District personnel regarding the medical condition or the medication prescribed for it.

○ The parent or legal guardian is solely responsible for supplying all medication with which assistance is requested:

a. No prescribed medications may be brought to school by pupils.
b. Parents or guardians shall deliver or cause to be delivered by an adult or an authorized employee of a pharmaceutical supplier, any prescribed medications to be administered under the provisions of this policy.
c. Each medication must be in a separate container which clearly identifies the number of pills, capsules, or dosages contained therein.

○ Whenever possible the parent or legal guardian should come to school to administer the medication.

NOTICE – SELF ADMINISTRATION OF ASTHMA INHALER AND EPINEPHRINE PEN

Should parent and physician authorize self-administration of Asthma inhaler or Epinephrine Pen, the District and school personnel are released from civil liability in the event of an adverse reaction to medication, overuse, improper administration, breakage, loss theft, sharing, playing with or careless storage of medication.

NOTICE - PLEASE READ BEFORE SIGNING REQUEST

A DISTRICT SCHOOL NURSE OR HEALTH CARE ASSISTANT IS NOT PRESENT AT THE SCHOOL SITE AT ALL TIMES OR ON ALL DAYS WHEN SCHOOL IS IN SESSION. THEREFORE, BECAUSE EMERGENCY ASSISTANCE MAY BE PROVIDED BY NON-MEDICALLY TRAINED DISTRICT PERSONNEL, PARENTS MUST ASSURE THAT PHYSICIANS PROVIDE COMPLETE, PRECISE, LEGIBLE DIRECTIONS AND INSTRUCTIONS. THE DISTRICT IS NOT RESPONSIBLE FOR NOTIFYING PARENTS BEFORE OR AFTER PRESCRIBED MEDICATION IS DEPLETED OR THE EXPIRATION DATE OCCURS. THIS REQUEST FOR DISTRICT ASSISTANCE WILL EXPIRE AT THE END OF THE SCHOOL YEAR IN, WHICH IT IS MADE.

SIGNATURE ON FRONT OF PAGE INDICATES THAT I HAVE READ AND FULLY UNDERSTAND THE REQUIREMENTS FOR SCHOOL PERSONNEL ASSISTING WITH THE GIVING OF MEDICATION TO MY STUDENT(S) AT SCHOOL.